



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGINSITE SOUTHEAST TEXAS
27087 GRATIOT AVENUE 2ND FLR
ROSEVILLE MI 48066

Respondent Name

New Hampshire Insurance Co

Carrier's Austin Representative

Box Number 19

MFDR Tracking Number

M4-13-0271-01

MFDR Date Received

September 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are the 2 copies of completed DWC Form-060 for the patient listed below. These completed forms are also accompanied by all supporting documentation that was stated as required and/or applicable."

Amount in Dispute: \$4,107.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor will need to correct their billing, including the correct form, and resubmit for review."

Response Submitted by: PAPPAS & SUCHMA, P.C. P.O. BOX 66655, AUSTIN, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20 and 29, 2011	Outpatient Services	\$4,107.75	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
 - 12 – SUBMISSION/BILLING ERROR(S).

Issues

1. Did the requestor submit medical fee dispute within one year from the date of service September 20, 2011?
2. Are the services in dispute payable?
3. Is the requestor entitled to reimbursement?

Findings

1. 228 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is September 20, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 25, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.
2. 28 Texas Administrative Code §134.20(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided..." Review of the submitted medical claim finds, disputed services billed on CMS form 1450, DWC060 indicates place of service "22". Centers for Medicare & Medicaid Services MM7631 defines place of service 22 – Outpatient Hospital, and the indicated bill type "131 – (Hospital, Outpatient, Admit thru Discharge Claim)". However, the NPI number associated with this facility indicates (Clinic/Center-Multi-Specialty). The insurance carrier denied the charges as 12 – "SUBMISSION/BILLING ERROR(S)". Review of the submitted documentation finds the insurance carrier's denial is supported as there is no evidence this provider is a licensed hospital.
3. The claim submission does not comply with TAC §134.20(b)(1) and therefore, no payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December , 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.